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Owner	Victoria Looper: Executive Director Clinical Education RN
Policy Area	Assessment, Documentation Standards & Orders
Applicability	CA - Divisional/ Regional
References	LA Region

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Assessment and Documentation Guidelines

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POLICY

In keeping with the mission and values of Providence, all patients in the acute care setting will be assessed in a timely manner utilizing the evidence-based resources for assessment and documentation in the electronic health record (EHR). Observation patients will be monitored as follows: non-telemetry patients are monitored according to Medical/Surgical guidelines and telemetry patients are monitored according to the Telemetry/ step down requirements and Observation unit guidelines. This policy does not apply to emergency department or post acute care patients.

PROCEDURE/GENERAL INSTRUCTIONS

Assessment frequency and documentation standards are accessible by clicking on Addendum A.

The nurse will assess the patient:

A. Utilizing the assessment tools and definitions of 'WDL' (within defined limits) in the EHR. When findings are consistent with the 'WDL', no further documentation is required. If they are not consistent with the standard for 'WDL', they are considered ABNORMAL and are documented.

B. LDA - Lines, Drains, Airway (LDAs) in the EHR (Electronic Health Record):

1. Document any device as 'present' that is currently present. If an LDA remains in place at the time of discharge, complete the LDA and document within the comments section that the patient is transferring to another facility with the LDA in place.
2. If a device appears as present in the EHR (it was not discontinued in the previous EHR) but is NOT present on admission, document as "REMOVED" and enter as the date and time, the date and time of admission. In addition, in narrative notes, document the device(s) was/were not present on admission (when available, may select "Not present on Admission" instead of a narrative note).

C. Perform assessments based on diagnosis and condition. Exceptions:
    1. Order from an LIP (licensed independent practitioner)/physician – the order supersedes these standards.
    2. Standards incorporated into a policy specific to a procedure or intervention - the specific standards supersede these standards.
    3. Emergency treatment exception applies when it is reasonable to believe that urgent interventions should supercede routine assessments.

D. Document as soon as practically possible following the care rendered.

E. Initiate the plan of care is per **Plan of Care regional policy.**

DEFINITIONS

Admission: The time the provider writes an order for an inpatient admission.

Individualized focused assessment: assessment based on patient's current diagnosis, chief complaints, history, present condition, potential complications and any other factors that may affect the patient condition.

LDA – Lines. Drains, Airway (intravenous, gastric, orthopedic devices, wounds/incisions, etc…).

Upon Assumption of Care: when a different nurse is assigned to continue the care of the patient (excludes coverage time)

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WDL – within defined limits.

Coverage time – period of time when one nurse observes and intervenes because the assigned nurse is on break or off the unit.

EHR – electronic health record.

LIP – licensed independent practitioner/physician/provider

Pediatric – newborn to age 13; Pediatric Intensive Care - 37 weeks gestation and/or two kilograms to 21 years.

REFERENCE(S)/RELATED POLICIES

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Women's Health Obstetric and Neonatal Nurses, Jul 30, 2010.

The Joint Commission Standards Interpretation Group: Response June 07, 2013

- **Original Question:** PC.01.03.01 relates to patient care plans. EP 23 states "The hospital revises plans and goals for care, treatment, and services based on the patient's needs." Would it be acceptable for the patient's individualized nursing care plan to be reviewed and the review documented once a day, or must it be reviewed and the review documented every shift?
- **SIG Response:** Thank you for your inquiry. It would need to be revised based on the changes with the patient. If there is a change in the patient's condition and needs only daily or every two or three days then that is when it would be revised. There is no requirement for revisions every shift or even daily. It is dependent on when it needs to be changed, or your hospital's policy.

California Code of Regulations: Article 6, 70537 Title 22 Pediatric patient definition: new born to age of 13.

California Children's Services (CCS): CCS manual of procedures: chapter 3.3.3 – 1 Pediatric patient definition for Critical Care: adolescents 14 years up to 21 years of age.

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COLLABORATION

This policy was developed in collaboration with the following involved Departments:

Regional Nursing Standards and Professional Practice; PTZ and PLCM-T Pediatrics; Perinatal Excellence Council; Regional Performance Improvement and Risk Management Council; Acute Rehabilitation Centers, PLCM-SP and PHC; Clinical Informatics Specialists

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Attachments

Assessment Frequency and Doc Guidelines Addendum A.pdf

Approval Signatures

Step Description	Approver	Date
Regional Site Adminsitrator	Wen Yun Chang: Senior Business Analyst	07/2023
Division CNO - South	Daniel Kelly: Division Chief Nursing Officer - South	07/2023
Exec Dir Clin Ops SoCal Reg	Kevin Streeter: Executive Director Clinical Operations	06/2023

Regional Site Adminsitrator	Wen Yun Chang: Senior Business Analyst	06/2023
Regional Policy Owner	Victoria Looper: Executive Director Clinical Education RN	06/2023

Applicability

CA - Regional/Divisional

Standards

No standards are associated with this document

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Addendum A: PSJH SC: Assessment and Documentation Guidelines for Nursing

Charting Element	Medical/Surgical	Pediatrics/PICU	Acute Rehab	Telemetry/step-down/AOU	Women's	SDS/SS/Med Pt on SS	Critical Care/NICU

Vital Signs
 	
T=temperature
P=pulse
R=respirations
BP=blood pressure
SpO2=pulse oximetry
 	
PG=practice guideline
SOC=standard of care
 	
LIP=order from a licensed practitioner with privileges to write orders
 	
MEWS=modified early warning system
	Admission: T, P, R, BP, pain, SpO2 (if indicated by condition)
	• performed within 1 hr of admission
	• documented within 2 hrs of admission
	
	Ongoing: 2 X/ shift
	• no more than 8 hours between vital signs(based on MEWS references)
	• as condition warrants
	
	Post-op:
	P, R, BP, SpO2
	• on arrival include T, then
	• 30 min X 1, then
	• Every hr X 3, then
	• Every 4 hrs(include T) x 24 hrs, then
	• Every 8 hrs or per unit SOC
		Admission: T, P, R, BP, pain, SpO2 (if indicated by condition)
		• performed within 1 hr of admission
		• documented within 2 hrs of admission
		
		Ongoing:
		• every 2 hr for respiratory patients
		• every 4 hrs/per PG/LIP order; as condition warrants
		
		Post-op:
		T, P, R, BP, SpO2
		• on arrival, then
		• every 4 hrs
		
		Critical Care (PICU) Peds
		T, P, R, BP, SpO2
		• within 15 min of admission
		• Documented within 2 hrs of admission .
		
		Ongoing:
		• every 2 hours
		• upon assumption of care
		• as condition warrants
		• SOC
			Admission: T, P, R, BP, pain, SpO2 (if indicated by condition)
			• performed within 1 hr of admission
			• documented within 2 hrs of admission
			
			Ongoing:
			• every shift
			• as condition warrants
				Admission: T, P, R, BP, pain, SpO2 (if indicated by condition)
				• performed within 1 hr of admission
				• documented within 2 hrs of admission
				
				Ongoing: 2 X/ shift
				• no more than 8 hours between vital signs(based on MEWS references)
				• as condition warrants
				
				Post-op:
				P, R, BP, SpO2
				• on arrival include T , then
				• 30 min X 1, then
				• Every hr X 3, then
				• Every 4 hrs (include T) X 24, then
				• Every 8 hrs or per unit SOC
					Admission: T, P, R, BP, pain, SpO2 (if indicated by condition) performed within 1 hr of admission
					• documented within 2 hrs of admission
					
					Ongoing: 2 X/ shift
					• no more than 8 hours between vital signs(based on MEWS references)
					• as condition warrants
					
					Post-delivery:
					BP, P, R
					• every 15 mins X 2 hours
					  ○ more frequently and of longer duration if complications occur
					• Temp
					  ○ every 4 hours X 2
					  ○ then, every 8 hours
					Post-op:
					P, R, BP, SpO2
					• on arrival include T, then
					• 30 min X 1, then
					• Every hr X 3, then
					• Every 4 hrs include T x 24 hrs, then
					• Every 8 hrs or per unit SOC
					On transition to PP:
					P, R, BP, SpO2
					• on adm , then
					• Q30 minX2, then
					• every 4X2, then
					• every 8, then
					(based on 5 ministry proposal for CPOE)
					Newborn
					• Assess the baby
					• every 30 minutes up to 2 hrs or as baby stabilizes
					• When stable, every 4 hours X 24 hours, then
					• every shift
						Admission: T, P, R, BP,pain, SpO2 (if indicated by condition)
						• performed within 1 hr of admission
						• documented within 2 hrs of admission
						
						Post-Op categories:
						P, R, BP, SpO2
						• on arrival (include T)
						Then
						Surgical:
						• every hour x 4, then
						• every 2 hrs until discharged
						Procedural:
						• every15 min x 4, then
						• every 30 min x 2, then
						• every1 hr until time of discharge or as ordered by physician.
						Cath Lab:
						• every15 min x 4, then
						• every30 min x 2, then
						• every 1 hr x 4 or as ordered by physician.
						Medical patients:
						• On admission and
						• as ordered by physician.
							Admission: T, P, R, BP, pain, SpO2 (if indicated by condition)
							• performed within 1 hr of admission
							• documented within 2 hrs of admission
							•
							
							Ongoing:
							• P, BP every 15 min until stable, then
							• every 1 hr or as ordered
							• RR every hr or as ordered
							• T, SpO2 every 4hrs or as ordered
							
							NICU only:
							T, P, R, BP, pain, SpO2
							• with feedings or with touch time
							BP frequency
							• Umbilical line
							  ○ every 1hr
							• Stable BP
							  ○ every 6 hrs
							• Stable baby
							  ○ every shift
							• **Vasoactive infusion:**
							Titrating
							  ○ Every 15 minutes until stable
							Non-titrating
							  ○ Every 1hr
							
							See specific policies for CRRT, ventilators, IABP, hypothermia, ICP

Height	**Admission:** performed and documented within 1hr	**Admission:** performed and documented within 1hr	**Admission:** performed and documented within 1hr	**Admission**: performed and documented within 1hr	**Admission:** performed and documented within 1hr	**Admission: performed and documented** within 1hr	**Admission:** performed and documented within 1hr

Addendum A: PSJH SC: Assessment and Documentation Guidelines for Nursing

Charting Element	Medical/Surgical	Pediatrics/PICU	Acute Rehab	Telemetry/step-down/AOU	Women's	SDS/SS/Med Pt on SS	Critical Care/NICU
					Newborns performed and documented within 2hrs		
Weight	**Admission:** performed and documented within 1hr of Admission	**Admission: performed and documented** within 1hr of Admission	**Admission: performed and documented** within 1hour of Admission **Ongoing** • weekly	**Admission: performed and documented** within 1hr of Admission	**performed and documented** within 1hr of Admission; Newborns 2 hrs **Ongoing-Newborns** • Daily	**Admission: performed and documented** within 1hr of Admission	**Admission:** performed and documented within 1hr Ongoing: • As ordered • NICU - daily
Cardiac Monitoring **No reference found**	**If cardiac monitoring**, post a rhythm strip: • Admission: Ongoing: • Every shift and • as needed/ordered by LIP	**If cardiac monitoring**, post rhythm strip: • Admission: Ongoing: • Every shift and • as needed/ordered by LIP		**If cardiac monitoring**, post rhythm strip: • Admission: Ongoing: • Every shift and • as needed/ordered by LIP	**N/A**	**During Procedures:** Cardioversion. • Pre and post procedure • as ordered by LIP TEE • as ordered by LIP	**Post rhythm strip:** **Admission** Ongoing: • Every shift and • Change of rhythm • **Invasive monitoring:** o every 4 hrs with other waveforms **NICU:** only when abnormalities identified
Head-to-Toe Patient Care Summary (PCS)	**ASSESSMENT** **Admission:** • performed within 4 hr of admission **Ongoing**: • within 4 hrs of start of shift • Individualized focused assessment o upon assumption of care and o as condition warrants **Post-op:** • full assessment on arrival to unit then • individualized focused assessment upon as condition warrants	**ASSESSMENT** **Admission:** • focused assessment performed within 15 min, • complete assessment within 2 hrs **Ongoing:** • full assessment every shift • focused assessment o every 4 hrs o upon assumption of care o as condition warrants **Post-op:** • full assessment on arrival to unit then • focused assessment o every 4 hrs o upon assumption of care o as condition warrants	**ASSESSMMENT** **Admission:** • performed within 4 hrs **Ongoing:** • every 24 hrs	**ASSESSMENT** **Admission:** • performed within 4 hrs **Ongoing**: • within 4 hrs of start of shift • Individualized focused assessment o upon assumption of care and o as condition warrants **Post-op:** • full assessment on arrival to unit then • individualized focused assessment upon assumption of care and • as condition warrants	**ASSESSMENT** **Admission:** • performed within 4 hrs **Ongoing**: • within 4 hrs of start of shift • Individualized focused assessment o upon assumption of care and o as condition warrants **Post-op:** • full assessment on arrival to unit then • individualized focused assessment upon assumption of care and • as condition warrants	**ASSESSMENT** **Admission:** • performed within 4 hrs. **Ongoing**: • within 4 hrs of start of shift • Individualized focused assessment o upon assumption of care and o as condition warrants **Post-op:** • full assessment on arrival to unit then • individualized focused assessment upon assumption of care and • as condition warrants	**ASSESSMENT** **Admission:** • performed within 4 hrs. **Ongoing**: • within 4 hrs of start of shift • Individualized focused assessment o upon assumption of care and o as condition warrants **Post-op:** • full assessment on arrival to unit

Addendum A: PSJH SC: Assessment and Documentation Guidelines for Nursing

Charting Element	Medical/Surgical	Pediatrics/PICU	Acute Rehab	Telemetry/step-down/AOU	Women's	SDS/SS/Med Pt on SS	Critical Care/NICU
Pain Assessment	**Admission: within 4 hrs** • Comprehensive pain assessment • Identify the acceptable level of pain **Ongoing** • Comprehensive pain assessment o with any new complaint of pain o shift assessment • Pain rating with o every set of full vital signs o prior to administering pain medication o following administration of pain medication to assess effect o following procedures/interventions associated with causing pain • Sedation level following administration of pain medication to assess effect						
Pressure Ulcer Risk Assessment (Braden Scale)	**Admission:** within 4 hrs Ongoing: every shift	**Admission:** within 2 hrs Ongoing: every shift	**Admission:** within 4 hrs Ongoing: every shift	**Admission:** within 4 hrs Ongoing: every shift	**Admission:** within 4 hrs Ongoing: every shift	**Admission:** - Surgical and procedural: within 4 hrs of Admission	**Admission:** within 4 hrs Ongoing: every shift **NICU:** every shift
Fall Risk Assessment	**Admission:** within 4 hrs Ongoing: every shift, transfer, post-fall	**Admission:** within 2 hrs Ongoing: every shift, transfer, post-fall	**Admission:** within 4 hrs Ongoing: every shift, transfer, post-fall	**Admission:** within 4 hrs Ongoing: every shift, transfer, post-fall	**Admission:** within 4 hrs Ongoing: every shift, transfer, post-fall	**Admission:** - Surgical and procedural: Within 4 hrs of Adm	**Admission:** within 4 hrs Ongoing: every shift and post-fall **NICU: NA**
Nutrition Risk	**Admission:** within 4 hrs	**Admission:** within 2 hrs	**Admission:** within 4 hrs	**Admission:** within 4 hrs	**Admission:** within 4 hrs	**Admission:** - Surgical and procedural: Within 4 hrs of Admission	**Admission: within 4 hrs** **NICU: NA**
Confusion Assessment Method □CA□/IC□ CA□□ *Note:* If the patient is alert □ oriented at time of admission, the screening is considered complete□							**Admission: within 4 hrs** Ongoing: daily **NICU: NA**
Pregnancy/ Lactation Screen	**Admission:** - Within 1hr of Admission	**Admission:** - Within 1hr of Admission	**Admission:** - Within 1hr of Admission	**Admission:** - Within 1hr of Admission	**Admission:** - Within 1hr of Admission	**Admission:** - Within 1hr of Admission	**Admission:** Within 1hr of Admission **NICU: NA**
Prior-to-Admission (PTA) Medications, Allergies(include Latex Screen), Immunizations PTA=prior to admission	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.	**Allergies within1 hr** **Admission:** Medications, Immunizations **- verify within 4 hrs.** *Nurse is verifier for PTA medications & allergy data. LIP holds primary responsibility.

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Charting Element	Medical/Surgical	Pediatrics/PICU	Acute Rehab	Telemetry/step-down/AOU	Women's	SDS/SS/Med Pt on SS	Critical Care/NICU
Suicide Risk	**Admission:** within 4 hrs	**Admission:** within 2 hrs	**Admission:** within 4 hrs	**Admission:** within 4 hrs	**Admission:** within 4 hrs	**Admission:** - Surgical and procedural: Within 4 hrs of Admission	**Admission:** within 4 hrs **NICU: NA**
Patient Profile * items: General Information, Current Health, Mutuality/Individual Preferences, Functional Level Prior/Current, Abuse Screen, Values/Beliefs/Spiritual Care	**Admission**: within 24 hrs	**Admission:** within 2 hrs Pediatric Safety assessment within 24 hrs	**Admission:** within 24 hrs	**Admission:** within 24 hrs	**Admission:** within 24 hrs		**Admission:** within 24 hrs **NICU: NA**
Plan of Care (admission)	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011	**Per regional policy - Plan of Care** CA-CLIN-20011 **NICU: NA**
Intake and Output	Every shift	Every shift	Every shift	Every shift	Every shift	When drainage catheter present (e.g., urinary, wound, NG)	When drainage catheter present • unstable every 1hr • stable every 2 hrs • as ordered Exception: anuric end-stage renal disease on dialysis
Vascular Site Assessment w/=with AMS=altered mental status IJ=internal jugular X/=times per	Peripheral IV Every 4 hours • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • vesicants Locked peripheral catheters • w/every access and infusion but at least 2 X/day	Peripheral IV Every 1 hour • Neonates • Peds Every hour • Vesicant infusion • vasoactive infusion	Peripheral IV Every 4 hours • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • vesicants Locked peripheral catheters • w/every access and infusion but at least 2 X/day	Peripheral IV Every 4 hours • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • vesicants Locked peripheral catheters • w/every access and infusion but at least 2 X/day	Peripheral IV Every 4 hours • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • vesicants Locked peripheral catheters • w/every access and infusion but at least 2 X/day	Peripheral IV Every 4 hours • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • vesicants Locked peripheral catheters • w/every access and infusion but at least 2 X/day	Peripheral IV-Adults Every 4 hrs • Alert/oriented adult w/non-irritant/vesicant infusion Every 1-2 hours • Adults w/AMS • Located in high risks sites: IJ and flexion points Every hour • Vesicant infusion • vasoactive infusion Locked peripheral catheters • w/every access and infusion but at least 2 X/day Peripheral IV-non-Adults Every 1 hr • Neonates • Peds
ADLs	Every shift	Every shift	Every shift	Every shift	Every shift	N/A	Every shift **NICU: NA**

Addendum A: PSJH SC: Assessment and Documentation Guidelines for Nursing

Charting Element	Medical/Surgical	Pediatrics/PICU	Acute Rehab	Telemetry/step-down/AOU	Women's	SDS/SS/Med Pt on SS	Critical Care/NICU
Nutrition	Every meal • % eaten Snack if ordered Supplements if ordered Every 12 hrs – Tube Feeding • Per ministry policy	Every meal • % eaten Breast milk • Time (breastfeeding) • Amount (pumped) Snack if ordered Supplements if ordered Tube Feeding - every 12 hrs • Formula type • Formula strength • Rate • Residual	Every meal • % eaten Snack if ordered Supplements if ordered Every 12 hrs – Tube Feeding • Per ministry p/p	Every meal • % eaten Snack if ordered Supplements if ordered Every 12 hrs – Tube Feeding • Per ministry p/p	Every meal • % eaten Breastmilk • Time (breastfeeding) • Amount (pumped) Snack if ordered Supplements if ordered Tube Feeding - every 12 hrs • Formula type • Formula strength • Rate • Residual	N/A	Every meal • % eaten Snack if ordered Supplements if ordered Every 12 hrs – Tube Feeding Per ministry p/p NICU-as ordered
Restraints	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry p/p
Hemodynamics	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	• Arterial, CVP & PA pressures per standard of care • Cardiac output per standard of care
Vasoactive IV Drug Administration	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	• BP every 1 hr when titrating or per standard of care • **NICU: see VITAL SIGNS above**
Neuromuscular Blocking Agents	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Initiation: • baseline neurological assessment, RASS & Train of Four (TOF) Ongoing: • TOF per standard of care **NICU: NA**
Temporary Pacemaker	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	• Assessment of patient's underlying rhythm 1X per shift **NICU: NA**
Ventilated Patients	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	Per Regional/ministry policy	• Assessment of lung sounds every 4 hrs & PRN **NICU** • Assessment of lung sounds every 2 hrs & PRN
Documentation	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift	Documentation should be as soon as practically possible following the care rendered but no later than immediately following the end of the shift

Status **Active** PolicyStat ID **18463351**

Providence
Santa Rosa
Memorial Hospital

Origination	06/1977
Last Approved	07/2025
Effective	07/2025
Last Revised	07/2025
Next Review	07/2027
Owner	Hiranya Abeysekara: Supervisor Clinical Laboratory
Area	Lab Services - Microbiology
Applicability	CA - Santa Rosa Memorial Hospital

Collection and Care of Urine Specimens

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PURPOSE/DEFINITION:

Collection of urine for laboratory examination is done to determine specific bacterial, cellular, or chemical properties to assist in diagnosis of disease entities. The amount of urine required and the time it is collected will vary according to the test to be performed.

POLICIES/GENERAL INSTRUCTIONS:

1. Urine supports rapid bacterial growth if left at room temperature; therefore, specimens should be taken to the laboratory within 15 minutes of collection for processing or refrigeration. If transport to the lab for is delayed, it can be refrigerated for up to two hours after which a new specimen must be obtained. If the specimen has been transferred into a grey top boric acid tube.
2. Urine tests that are sent to reference laboratory may require special handling and/or preservatives. Refer to the Reference Laboratory's collection information.
3. If patient is menstruating, the perineal area should be cleansed and a fresh vaginal tampon inserted before specimen is collected. The presence of RBC's will be detected on microscopic examination.
4. Label generated from the Laboratory Information System (LIS) must be affixed to each specimen container. During downtime, alternate labeling is acceptable.
5. Specimen must be placed in a biohazard bag, sealed, and transported to the lab.

6. Hazardous specimen should be clearly marked; ie red bagged or labeled with special sticker. If possible there should be three-day delay before collection of urine from Radiation Therapy.
7. For Urine Culture, clean-catch specimen, catheter aspiration, and pedi-bagged specimens are acceptable. Quantitative studies of organisms are done to determine the presence, type, and degree of pathogens in the urine . One (1) to five (5) milliliters of urine is required.
8. Routine Macroscopic Urinalysis includes a study of general appearance, pH, specific gravity, protein, glucose, ketones, occult blood, bilirubin. Routine Microscopic Urinalysis includes sediment analysis. Twelve (12) milliliters of urine is optimal.
9. Twelve or 24 hour Creatinine and Urea Clearance require urine and blood specimen. The blood is drawn during the collection period. It is part of the tests to determine the excretion rate.

EQUIPMENT FROM FLOOR SUPPLY:

1. A sterile urine container collection kit for Routine Urinalysis, Urine Culture, or Random chemistry test
2. Grey top BD Boric Acid tube for Culture and Sensitivity testing.
3. 24-hour urine collection bottle for timed urine tests
4. For Catheters, syringe with small gauge needle and prep pads
5. For babies or young children, plastic pedi-bag
6. Computer generated specimen identification label.
7. Clean urinal, appropriate container and graduated pitcher.
8. Electronic health record barcoded specimen label

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PROCEDURE:

1. Explain midstream clean catch procedure to patient.
2. Have patient wash hands!
3. Wash and glove your hands.
4. Midstream Collection:
    a. MALE: cleanse urethral meatus with three changes of castile soap towelettes, starting at the urethral orifice and cleansing away from the orifice (if foreskin is present, it must e retracted throughout the entire procedure). Initiate the stream of urine. Wait a few seconds, then collect the midstream specimen by passing the sterile collection cup into the stream of urine without stopping the flow. Optimal volume to collect 12 milliliters and no more than half full. Remove and close container securely. Wipe dry any excess urine on outside of container. Label properly.
    b. FEMALE: Retract labia minora with non-dominant hand. Cleanse vulvar area with three changes of castile soap towelettes beginning above the urethral orifice and moving downward posteriorly; ie front to back. Maintain hold on labia and initiate stream of urine. Wait for a single stream to be achieved. Collect the midstream specimen by passing the sterile collection cup into the stream of urine without

stopping the flow. Obtain at least 12 milliliters and no more than half full. Remove and close container securely. Wipe dry any excess urine on outside of container. Label properly.

5. Pedi-Bag collection: Before attaching bag, perform careful perineal prep and cleansing as noted above or as preferred by pediatrician. The bag containing the specimen is not to be sent to the laboratory, but rather use a 12 milliliter syringe to transfer this to a sterile specimen container. Indicate on the container that this is a "bagged" urine specimen. This assists the physician and Clinical Laboratory Scientist (CLS) to interpret any mixed growth with occurs with this type of collection when Urine Culture is performed.
6. Catheter Aspiration: Only to be done by RNs. Cleanse the surface of the collection port (just below the "Y" connection) with alcohol prep pad. Allow to air-dry thoroughly. Puncture the port with a small gauge needle and syringe and withdraw specimen. Aspiration of the catheter line tubing is contraindicated when a collection port is available. NEVER take urine from the collecting bag or lower portion of the collection tubing. NEVER disconnect catheter tubing for the purpose of obtaining a specimen . After obtaining the specimen, cap the syringe securely and label properly. Please note this was a "CATHETER" aspiration collection. The laboratory must know this so that the correct quantitative studies are done for Urine Culture. If desired, the urine specimen may be aseptically transferred to a sterile specimen container by removing the needle from the syringe and carefully expelling the urine into the sterile container.
7. Timed Urine Specimens: 12 hour, 24 hour collections (Creatinine, Urea Clearance, other timed Urine tests)
    a. Timed urine specimens are done to determine a specific function of the kidneys during a designated period of time. The length of study and type of collection bottle will vary according to the test ordered. Some will required preservatives.
    b. All timed urine specimens are started with an empty bladder and ended when the bladder is emptied for the final specimen. The exact time of starting and ending specimens should be indicated on label. If possible timed specimens should be scheduled to end at 0700.
    c. Explain the test and its duration to the patient to insure his/her cooperation in obtaining an accurate collection. Instruct the patient that he/she is to void into a suitable container or bedpan for the duration of the test procedure and to notify a nurse of each voiding so that it can be added to the specimen container. It is important that the patient be instructed to void in a separate container and to avoid any contamination of the urine with stool.
    d. Keep the urine specimen refrigerated during the collection period.
    e. At the end of the test period, have the patient empty his bladder again, add that specimen to the collection. Note the time of the last voiding on the specimen label. This ends the timed urine collection.
    f. For Creatinine and Urea Clearance, it is required to obtain blood Creatinine or Urea specimen during the urine collection time to determine excretion rate.
    g. Order the test in LIS and respond to the prompts if appropriate. On the LIS label, write the collection time/period and sign.
    h. Submit the specimen to the laboratory immediately.

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Approval Signatures

Step Description	Approver	Date
Laboratory Services Medical Director	Wanhua Yang: MD	07/2025
	Hiranya Abeysekara: Supervisor Clinical Laboratory	07/2025

Applicability

CA - Providence Santa Rosa Memorial Hospital

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Standards

No standards are associated with this document

Status **Active** PolicyStat ID **19033234**

Providence
Santa Rosa
Memorial Hospital

Origination	07/2025
Last Approved	09/2025
Effective	10/2025
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Next Review	09/2028
Owner	Dalila Formato: Project Coordinator
Area	Infection Prevention Services
Applicability	CA - Santa Rosa Memorial Hospital

Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

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Purpose

In keeping with the mission and values of Providence, Providence Santa Rosa Memorial Hospital (PSRMH) adopts the system policy titled " Catheter Associated Urinary Tract Infection (CAUTI) Prevention Viewing PSJH-CLIN-1210 Catheter Associated Urinary Tract Infection (CAUTI) Prevention **with the exception of the information below:**

Urine Culture Collection

Replacing the Foley catheter before collecting a urine sample for culture is essential to reduce the risk of contamination, which can lead to false positives indicating a urinary tract infection (UTI). False positives may result in misdiagnosis and inappropriate treatment. Therefore, it is crucial to follow proper procedures to ensure accurate diagnostic results.

For patients with a Foley catheter in place for **24 hours or more**, consult the attending healthcare provider before collecting a urine sample for microscopy or culture. Obtain an order to remove the existing catheter, and request an order for straight catheterization if obtaining a midstream specimen is challenging.

If the healthcare provider decides to continue using the urinary catheter, request an order to replace the catheter before collecting the urine sample to minimize contamination risks. Ensure the specimen is

promptly transferred to the laboratory, ideally within 15 minutes, to maintain its integrity for accurate testing and analysis.

Daily CHG Treatment

Daily CHG treatment will be performed on patients having a indwelling urinary catheter of any type, including those patients with catheters present on admit.

PSRMH Adult Acute Urinary Retention Pathway

Adhere to the attached **Santa Rosa Memorial Hospital Acute Urinary Retention Protocol (PSRMH Nursing Pathway for Adult Acute Urinary Retention)** when ordered.

Reference

PSJH-CLIN-1210 Catheter Associated Urinary Tract Infection (CAUTI) Prevention

Carlee Hoxworth MPH, CIC , Addressing [Urinary Tract Infection]. In: Dean R, Popescu S, eds. APIC Text. [Revised January 26, 2024]. Available at 34. Urinary Tract Infection | Prevention Measures for Healthcare-Associated Infections | Table of Contents | APIC. Accessed July 30, 2024.

Approvals

Infection Prevention Committee 09/2025
Medical Executive Committee 09/2025
Community Board 09/2025

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Attachments

PSRMH Nursing Pathway for Adult Acute Urinary Retention

Approval Signatures

Step Description	Approver	Date
	Dalila Formato: Project Coordinator	10/2025

Applicability

CA - Providence Santa Rosa Memorial Hospital

Standards

No standards are associated with this document

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